Texas Department of Insurance, Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor's Name and Address: Dr. Jeffrey D. Reuben 4126 Southwest Freeway, Ste. 700 Houston, TX 77027	MFDR Tracking #: M4-07-3685-01 DWC Claim #: [redacted] Injured Employee: [redacted]
Respondent Name and Box #: St. Paul Mercury Insurance Rep. Box #5	Date of Injury: [redacted] Employer Name: [redacted] Insurance Carrier #: [redacted]

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Requestor's Position Summary: "The carrier has reimbursed the claim incorrectly. Procedure 72141 was denied. The aforementioned CPT Code is separate and requires payment when billed with modifier 26..."

Principle Documentation:

1. DWC 60 package
2. Total Amount Sought - $106.84
3. CMS 1500(s)
4. EOB(s)

Sent
SEP 11 2007
TX DEPARTMENT OF INSURANCE
DIVISION OF WORKERS'
COMPENSATION

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Respondent's Position Summary: "Carrier stands firm with the denial. The MRI of the cervical done on 12-22-06 was a repeat which was not pre-authorized. Initial MRI of the cervical was done on 09/-26-06."

Principle Documentation:

1. Response to DWC 60

PART IV: SUMMARY OF FINDINGS

Eligible Dates of Service (DOS)	CPT Code and Calculations	Part V Reference	Amount in Dispute	Ordered Amount
12/22/06	72141-26 ($85.41 x 125%)	1, 2, 3	$106.84	$106.76
Total Due:			$106.84	$106.76

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

Section §413.011(a-d) titled, *Reimbursement Policies and Guidelines*, and Division Rule 134.202 titled, *Medical Fee Guideline* effective August 1, 2003, sets out the reimbursement guidelines.

1. The service was denied by the Respondent with reason code "62 – Payment denied/reduced for absence of or exceeded pre-certification/authorization."

2. According to Rule 134.600(h)(8) a repeat individual diagnostic study with an established fee in the current Medical Fee Guideline that is greater than $350.00 requires preauthorization. The Requestor billed $200.00

for the technical component of the MRI; therefore, preauthorization was not required and the Respondent has incorrectly denied the services. Furthermore, the Respondent purports that the MRI of 12.22/06 was a second MRI; however, per Rule 133.307(j)(1)(D) the Respondent did not submit documentation to support their claim. Per Rule 134.202(b) and (e)(1) reimbursement at the maximum allowable reimbursement of $106.76 ($85.41 x 125%) is recommended.

3. Per review of Box 32 on CMS-1500, zip code 77027 is located in Harris County.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code Sec. §413.011(a-d), §413.031 and §413.0311
28 Texas Administrative Code Sec. §134.1, §134.202, §134.600, §133.307
Subchapter G, Chapter 2001, Texas Government Code

PART VII: DIVISION DECISION AND/OR ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code, section §413.031, the Division has determined that the Requestor is entitled to reimbursement. The Division hereby **ORDERS** the Carrier to remit to the Requestor the amount of $106.76 plus applicable accrued interest per Division Rule 134.130 due within 30 days of receipt of this Order.

ORDER;

Authorized Signature	Marguerite Foster Team Lead, Medical Fee Dispute Resolution	September 10, 2007 Date

PART VIII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division Rule 148.3(c).

Under Texas Labor Code Section 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code Section 413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.